Canadian Audiologist

The Official Publication of the Canadian Academy of Audiology

How Do We Incorporate Hearing Screening Into Primary Care?

Published July 4th, 2016

Barbara Weinstein, PhD, CCC-A

Reprinted with permission from The ASHA Leader,
leader.pubs.asha.org/article.aspx?articleid=2527223

Given a lack of government mandates for attention to declining hearing, the audiology community needs to raise physicians' awareness of what happens when we ignore it.

To whom does Mr. G turn? He has a hearing loss, and his family complains that he does not hear or understand his grandchildren. However, at his "Welcome to Medicare" visit for new beneficiaries, his family physician does not screen him for hearing loss or recommend he see an audiologist.

Why? At least in part, it's because hearing loss screening is not required: Screening for asymptomatic hearing loss in adults 50 and older has been assigned an "I" rating by the U.S. Preventive Services Task Force (USPSTF) of the Agency for Healthcare Research and Quality (AHRQ). And, according to the USPSTF definition, an "I" rating means "the current evidence is insufficient to assess the balance of benefits and harms of the service."

Compare that rank to USPSTF's "A" rating—a flat-out recommendation to provide the service.

So it's not surprising that Mr. G's physician does not screen for hearing loss and/or refer Mr. G to an audiologist. Given this situation, what are audiologists to do? Do we have a responsibility to educate physicians about protocols to follow when symptomatic people express concerns about their hearing? Do we have a role in educating asymptomatic people about hearing health and "unintended consequences" of neglecting a sense that is crucial to engagement, quality of life and quality of care?

Would it help if audiologists' reports to physicians included information about how hearing health care interventions (such as hearing aids) have improved patient communication with family and friends, increased social engagement and bolstered quality of life?

My answer to all these questions is a resounding "yes." We need to get the message out that our hearing care services improve health outcomes, optimize patient-centered care and boost quality of life. If more physicians get this message, we will more likely see hearing screening and audiologist referrals included in older adults' medical visits.

Overlooked and detrimental

A gradually acquired and chronic medical condition, age-related hearing loss is underreported and undertreated. Most adults with the condition do not consult their physicians about it. However, those who do discuss their hearing status with their physician share some distinguishing features. They:

- Rate their hearing quality as poor.

- Experience pressure or instigation from others, especially family members, to seek help.
- Are willing to try hearing aids.
- Self-perceive the psychosocial impact of hearing loss (see sources below).

Evidence continues to mount on the independent association between hearing loss and many negative outcomes: functional dependence, cognitive decline, social isolation, falls, poor physician-patient communication and even mortality. However, physicians may be unaware of the negative health consequences of hearing loss and of the array of treatment options (other than hearing aids) available.

Another well-kept secret is that early detection of preventable functional impairment—such as psychosocial difficulties associated with hearing loss—holds the key to reducing disability and maintaining independence.

A call to action

A report issued in October by the President's Council of Advisors on Science and Technology (PCAST) is a call to action. The report endorses greater access to hearing aid technology and consumer hearing products, especially for people with mild to moderate hearing loss. (Read ASHA's response to the report.)

> "Early detection of preventable functional impairment—such as psychosocial difficulties associated with hearing loss—holds the key to reducing disability and maintaining independence."

And it's important to note that the USPSTF's "I" rating does not apply to those seeking evaluation for perceived hearing problems. The USPSTF recommends that symptomatic adults have their hearing assessed objectively and treated when indicated.

The PCAST and USPSTF recommendations underscore the need for us to disseminate messages about the evidence-based efficacy of hearing health care interventions. Hearing aids reduce caregiver burden, reduce depressive symptoms and boost social engagement—factors critical to positive health outcomes and quality of life. Aural rehabilitation reduces self-perceived psychosocial hearing difficulties.

Should a physician ask you about referral guidelines, I suggest recommending that they refer patients to you who:

- Rate their hearing quality as poor.
- Experience pressure from family members to seek help.
- Are willing to try hearing aids.
- Self-perceive the psychosocial impact of hearing loss.
- Are depressed, feeling lonely or have fallen within the past month—all risk factors for untreated hearing loss.

It is also helpful if audiologists go well beyond the audiogram in communicating with patients and referring physicians, sharing information about diagnosis and treatment outcomes, perhaps in the form of a Hearing Loss Prescription as shown in the accompanying graphic. Relating our patients' everyday experiences and social lives to hearing aid use is the road less traveled, but it is the fork well worth taking.

Sources

Chien, W., & Lin, F. (2012). Prevalence of hearing aid use among older adults in the United

States. *Archives of Internal Medicine*, 172(3), 292–293. [Article] [PubMed]

Fischer, M. E., Cruickshanks, K. J., Wiley, T. L., Klein, B. E. K., Klein, R., & Tweed, T. S. (2011). Determinants of hearing aid acquisition in older adults. *American Journal of Public Health*, 101, 1449–1455. [Article] [PubMed]

Wallhagan, M. (2010). The stigma of hearing loss. *Gerontologist*, 50, 66–75. [Article] [PubMed]